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AUTHOR Rose, Laura
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ABSTRACT

This report, written for the Wisconsin State Legislative Council's Special Committee on Mental Health Issues, describes mental health services in Wisconsin. Part I summarizes the state and county organizational structures and responsibilities for mental health services and provides an introductory summary of funding sources for those services. Part II discusses inpatient mental health services provided through specialty hospitals, psychiatric units at general hospitals, and nursing homes. It includes information on service requirements, numbers of patients served, patients' lengths-of-stays and diagnostic categories, and county expenditures for services. Part III describes outpatient, residential, and other community-based mental health services. It includes information on the types of services and programs provided, numbers of clients served, clients' diagnostic categories, and county expenditures for services. Part IV discusses funding sources and amounts for county expenditures for mental health services in Wisconsin and for the state operation of Mendota and Winnebago Mental Health Institutes. Twelve tables are included, and five appendices provide data on inpatient, outpatient, sheltered employment and residential programs expenditures by county mental health boards as well as types of community services for which fees are exempt, optional, or mandatory, (NB)

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MENTAL HEALTH SERVICES IN WISCONSIN

STAFF BRIEF 86-8

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Wisconsin Legislative Council Staff — Madison, Wisconsin

Special Committee on Mental Health Issues — July 16, 1986

STAFF BRIEF 86-8*

MENTAL HEALTH SERVICES IN WISCONSIN

INTRODUCTION

On February 20, 1986, the Legislative Council established the Special Committee on Mental Health Issues, pursuant to a December 20, 1985 letter to the Legislative Council from Senator Fred A. Risser. The Committee is directed to undertake a thorough examination of present mental health concerns, including a study of: (a) community and institutional programs and services for the mentally ill; (b) present civil commitment standards and alternatives thereto; and (c) services available to the mentally ill in prisons and jails.

This Staff Brief describes mental health services in Wisconsin and is organized as follows:

Part I summarizes the state and county organizational structures and responsibilities for mental health services and provides an introductory summary of funding sources for these services.

Part II discusses inpatient mental health services provided through specialty hospitals, psychiatric units at general hospitals and nursing homes. It includes information on service requirements; numbers of patients served; patients' lengths of stays and diagnostic categories; and county expenditures for these services.

Part III describes outpatient, residential and other community-based mental health services. It includes information on the types of services and programs provided; numbers of clients served; clients' diagnostic categories; and county expenditures for these services.

Part IV discusses funding sources and amounts for county expenditures for mental health services in Wisconsin and for the state operation of Mendota and Winnebago Mental Health Institutes.

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*This Staff Brief was prepared by Laura Rose, Staff Attorney, Legislative Council Staff.

PART I

STATE AND COUNTY ORGANIZATION AND RESPONSIBILITIES

Both the state and counties in Wisconsin are assigned responsibilities related to mental health services. State responsibilities are statutorily assigned primarily to the Department of Health and Social Services (DHSS) and include the state's regulatory and administrative authority over mental health services, as well as the operation of the state's two mental health institutes. Counties are primarily responsible for providing or making available community-based outpatient mental health services and inpatient services.

This Part briefly describes the state and county responsibilities for mental health services and the state and county organizational structures for those services. It also provides an introductory summary of the funding sources for mental health services. Funding sources are described in greater detail in Part IV of this Staff Brief.

A. STATE ORGANIZATION AND RESPONSIBILITIES

Within the DHSS, several divisions have responsibility for mental health. The DHSS's Division of Care and Treatment Facilities maintains and operates the state's two mental health institutes, Winnebago Mental Health Institute and Mendota Mental Health Institute [s. 46.03 (1), Stats.].

The DHSS's Division of Health, Bureau of Quality Compliance, is responsible for the establishment and enforcement of standards for psychiatric hospitals, psychiatric units of general hospitals and nursing homes [ss. 50.01 through 50.39, Stats.].

The DHSS's Division of Community Services, Office of Program Initiatives, is responsible for the implementation and administration of the Community Options Program (COP). The purpose of the COP is to identify persons at risk of entering a nursing home. The COP is described in Section B, 3, of this Part.

Also in the Division of Community Services, Bureau of Community Programs, the Office of Mental Health is assigned major regulatory responsibility for mental health services. The Office:

1. Certifies county mental health boards to assure that they are in compliance with the statutes governing their creation.

2. Periodically reviews and evaluates county mental health board's programs to assure their compliance with the provisions of ch. 51, Stats.

3. Consults with county mental health boards to assist in defining local needs and in establishing programs.

4. Develops and implements a uniform cost reporting system for county-operated psychiatric hospitals established by counties with populations less than 500,000 [s. 51.42 (7) (a), Stats., as affected by 1985 Wisconsin Acts 29 and 176].

The Office of Mental Health also develops standards for the implementation and administration of the Community Support Program (CSP), and provides assistance, consultation and ongoing monitoring to CSP's. Under the statutes, county mental health boards must establish CSP's to provide comprehensive services to mental health clients. See Section B, 2, of this Part [s. 51.421 (3), Stats., as affected by 1985 Wisconsin Act 29].

B. COUNTY ORGANIZATION AND RESPONSIBILITIES

1. Organizational Structure

Except in Milwaukee County, mental health services are provided under one of the following organizational forms authorized by the statutes:

a. Human services board. Section 46.23, Stats., authorizes a county to integrate all of its social services and mental health, developmental disabilities, alcoholism and drug abuse services into a single board, called a human services board. Thirteen of Wisconsin's 72 counties use this form of organization.

b. Mental health board. Section 51.42 (3) (a), Stats., as affected by 1985 Wisconsin Acts 29 and 176, allows a county to provide mental health, alcoholism and drug abuse services under a board which is separate from boards with jurisdiction over social services and developmental disability services. These boards are commonly called "s. 51.42 boards." Four counties have s. 51.42 boards.

c. Combined mental health and developmental disabilities board. Section 51.437 (4g) (b), Stats., as affected by 1985 Wisconsin Acts 29 and 176, allows a county to provide mental health, alcoholism, drug abuse and developmental disability services under a combined board. Thirty counties have combined mental health and developmental disabilities boards.

d. Multi-county boards. Section 51.42 (3) (a), Stats., as affected by 1985 Wisconsin Acts 29 and 176, authorize counties to create multi-county boards which may be organized to provide mental health services only, developmental disability services only or both types of services. There are eight multi-county boards in Wisconsin, serving 24 counties.

Under s. 46.21, Stats., in Milwaukee County, a single director of Health and Human Services oversees funding and policy decisions for social, mental health, and developmental disability services, but separate social service and mental health agencies administer these programs.

Throughout this Staff Brief, the board (or department) which provides mental health services will be referred to generally as the "county mental health board."

2. Responsibilities

The legislative declaration of policy to the State Mental Health Act [ch. 51, Stats.] states that:

> It is the policy of the state to assure the provision of a full range of treatment and rehabilitation services in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse...which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care [s. 51.001 (1), Stats.].

The statutes specifically state that counties have "the primary responsibility for the well-being, treatment and care of mentally ill...residing within their respective counties" [s. 51.42 (1) (b), Stats., as affected by 1985 Wisconsin Act 29] and require that specific mental health services be provided by county mental health boards.

Services provided to the mentally ill in a county may be provided either directly by a county mental health board or by private or other public agencies under contract with the county mental health board. In addition, counties may contract with the state to serve county residents in one of the state's two mental health institutes.

Section 51.42 (3) (ar) and (4) 1 to 5, Stats., as affected by 1985 Wisconsin Acts 29 and 176, provides that, within the limits of state and

federal funds and county funds appropriated to match state funds, county mental health boards shall make the following services available for residents within the board's jurisdiction:

a. In collaboration and cooperation with public health and other groups, programs of prevention.

b. Comprehensive diagnostic and evaluation services.

c. Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services for mental health clients residing in the community.

d. Related research and staff in-service training.

e. Continuous planning, development and evaluation of programs and services.

Also, to the extent that federal, state and county matching funds are available, county mental health boards must establish a CSP. A CSP provides comprehensive services to mental health clients residing in the county through an identified treatment program and staff. Services provided or coordinated through the CSP must include:

a. Assessment and diagnosis.

b. Identification of persons in need of services.

c. Case management.

d. Crisis intervention.

e. Psychiatric treatment, including medication, supervision, counseling and psychotherapy.

f. Teaching daily living skills.

g. Psychosocial rehabilitation, which may include services provided by day treatment programs.

h. Client advocacy.

i. Residential services.

j. Recreational activities [s. 51.421 (2), Stats.].

3. Optional Program

Counties may, but are not required, to participate in the COP. The purpose of the COP is to identify persons at risk of entering a nursing home or an institute for the developmentally disabled to determine if they can be provided community services sufficient to prevent institutionalization. The COP serves five targeted categories of disabled individuals; one of the targeted groups is the chronically mentally ill.

C. FUNDING SOURCES SUMMARY

1. State Functions

Funds for state operation of Mendota and Winnebago Mental Health Institutes come primarily from fees charged counties for persons placed at the Institutes and state general purpose revenues (GPR).

Funds for the DHSS's regulatory functions come primarily from GPR.

2. Counties' Services

The primary revenue source for counties for mental health services is community aids funds allocated by the state to the counties. Community aids funds consist of a combination of state and federal funds. For the 1985-87 biennium, approximately 2/3rds of the community aids allocation is from state GPR and approximately 1/3rd consists of federal funds.

Counties are required to provide matching funds which equal 9% of a county's total community aids allocation. Many counties provide funds in excess of this 9% required match.

Other sources of revenue for county mental health programs include fees collected from county mental health board clients, reimbursements from the Medical Assistance program and private insurance.

PART II

INPATIENT MENTAL HEALTH SERVICES

For the purposes of this Part, inpatient mental health services refers to services provided in a hospital, mental health institute or nursing home on a 24-hour basis to individuals with mental illness. Individuals may be involuntarily committed to an inpatient facility pursuant to s. 51.20, Stats.; detained in an inpatient facility on an emergency basis pursuant to s. 51.15, Stats.; protectively placed in an inpatient facility (usually a nursing home) pursuant to s. 55.06 (9), Stats.; or voluntarily admitted pursuant to an inpatient facility pursuant to s. 51.10, Stats. Children may be voluntarily admitted to mental health facilities under s. 51.13, Stats.

This Part discusses: (a) the types of inpatient mental health facilities; (b) the services and programs provided in inpatient facilities; (c) the numbers of patients in inpatient facilities; (d) the diagnostic categories of patients in inpatient facilities; (e) the patients' lengths-of-stays in inpatient facilities; and (f) inpatient mental health expenditures.

A. TYPES OF FACILITIES

In Wisconsin, inpatient care for the mentally ill is provided in the following types of facilities:

1. Specialty Hospitals

A "specialty hospital" is a facility which exclusively provides inpatient mental health services and care for persons with mental illness. Specialty hospitals include private psychiatric hospitals, county-operated psychiatric hospitals and the state mental health institutes (Winnebago and Mendota Mental Health Institutes).

2. Psychiatric Units in General Hospitals

A "psychiatric unit in a general hospital" is a unit in a general hospital which provides inpatient mental health services and care for persons with mental illness. A general hospital is a hospital which

provides care to persons with many different types of illnesses other than mental illness.

3. Nursing Homes

A "nursing home" provides room, board, nursing services and personal care to persons with mental illness, as well as to persons suffering from other conditions requiring 24-hour care and supervision.

B. SERVICE REQUIREMENTS

1. Specialty Hospitals and Psychiatric Units in General Hospitals

Services provided to mentally ill patients in county-operated or private psychiatric hospitals and psychiatric units in general hospitals are regulated by administrative rules promulgated by the DHSS [ss. HSS 61.70 to 61.72 and 61.78 to 61.79, Wis. Adm. Code].

The DHSS rules include minimum qualifications for staff and staff-to-patient ratios for these facilities. The facilities must provide the services of psychiatrists, nurses, occupational therapists, social workers and psychologists to meet the needs of patients. When children are present, staff-to-patient ratios are increased [s. HSS 61.71 (1), Wis. Adm. Code].

The DHSS rules require each patient, upon admittance to a facility, to be evaluated by the professional staff within 48 hours after admission. A treatment plan must be formulated and maintained for each patient and periodically reviewed. At least weekly, progress notes must be written regarding the patient's condition [s. HSS 61.71 (2) (b), Wis. Adm. Code].

The rules encourage the inpatient facilities to make the following programs available at the facility:

a. Drug and somatic therapy.

b. Group therapy programs.

c. Activity therapy programs, both in the facility and in the community, which provide recreational and other activities to meet the social, diversional and developmental needs of all patients.

d. Industrial therapy programs which provide work situations for patients. Industrial therapy may be provided only upon the written order

of a psychiatrist, must be reviewed weekly and requires a new order from the psychiatrist weekly.

The administrative rules emphasize that inpatient mental health services in psychiatric or general hospitals are one component of community-based comprehensive mental health programs provided by the county mental health board. The rules also direct that inpatient service programs must be integrated and coordinated with all services provided by the county mental health board. These inpatient programs must attempt to locate alternative care settings in the community for patients, refer appropriate patients to vocational rehabilitation and maintain the patient's family and community ties [ss. HSS 61.71 (2) (d) through (g); s. 61.71 (2) (j), Wis. Adm. Code].

2. Nursing Homes

Under DHSS rules, nursing homes are licensed by DHSS according to whether the level of care is skilled nursing care or intermediate nursing care [s. HSS 132.14, Wis. Adm. Code].

Facilities licensed as skilled nursing care facilities provide services to residents, pursuant to a physician's orders, which require the skills of a registered or licensed practical nurse in order to be safely and effectively performed [s. HSS 132.13 (2), Wis. Adm. Code].

Nursing homes licensed as intermediate care facilities provide care to residents with long-term illnesses or disabilities who need medical or nursing services to maintain stability. Services provided include basic nursing care and physical, social, emotional and other restorative services. The services are provided under periodic medical supervision, with visits by a physician at least every 90 days [ss. HSS 132.13 (8) and 132.61 (2) (b) 2, Wis. Adm. Code].

Under DHSS administrative rules, all nursing homes must conduct a medical examination and take a medical history within 48 hours of the resident's admittance to the facility. A plan of care for nursing services must be developed and implemented within four weeks of the resident's admittance [ss. HSS 132.52 (2) and 132.60 (8), Wis. Adm. Code].

Medical and nursing services must be provided to all nursing home residents; the level of service required varies depending upon whether the facility is licensed to provide skilled or intermediate nursing care. All facilities must provide specialized rehabilitative services as needed by residents to improve or maintain their level of functioning. Facilities must also provide social services and an activity program, coordinated by persons meeting specified educational requirements [ss. HSS 132.61, 132.64, 132.68 and 132.69, Wis. Adm. Code].

C. NUMBERS OF PATIENTS SERVED

This section provides information on patients in the two types of inpatient mental health facilities. Data relating to patients receiving mental health services in specialty hospitals and psychiatric units of general hospitals was obtained from DHSS's Office of Mental Health. Data relating to patients receiving mental health services in nursing homes was obtained from DHSS's Division of Health, Center for Health Statistics. Because the data on specialty hospitals and psychiatric units and the data on nursing homes are reported in different forms, direct comparisons cannot be made between the two different types of inpatient facilities. However, the data does give a general picture of the numbers of patients, in a given year, in each type of facility.

1. Specialty Hospitals and Psychiatric Units in General Hospitals

Tables 1 and 2, below, contain data for specialty hospitals and psychiatric units in general hospitals. Table 1 gives the total numbers of clients receiving inpatient mental health services in these facilities in each year from 1980 to 1984, broken down by age groups.

Table 2 summarizes, for clients who receive any mental health services (inpatient or other services, including outpatient services), the percentage who received inpatient services in specialty hospitals and psychiatric units of general hospitals from 1980 to 1984.

Several factors should be noted in reviewing Tables 1 and 2:

a. Data for 1985 are not included because the data has not yet been processed by the Office of Mental Health.

b. Data presented for 1983 and 1984 are incomplete. Beginning in 1983, the Office of Mental Health began to change from the Transitional Information System (TIS) data collection system to the Client Services Information System (CSIS) data collection system. Only data collected through TIS are shown in Tables 1 and 2. Twenty-one county mental health boards, covering 23 counties, began converting their data from TIS to CSIS in 1983 and 1984; those counties are listed in Appendix A. Thus, data from these 21 county mental health boards in 1983 and 1984 are incomplete; only data collected by these boards on TIS are included.

c. Unduplicated client counts are represented in Tables 1 and 2. That is, if one client had more than one inpatient admission in a given year, that client is only counted once.

Table 1 shows a steady increase in the total numbers of clients served in specialty hospitals and psychiatric units in general hospitals from 1980 to 1983. There were steady increases in the numbers of clients served in these years for every age group, except for the 13 to 17 years age group, in 1981, and the 65 years and older age group, in 1981 and 1982. The total number of clients served in 1983, 6,255, represents an 11% increase over the 5,626 clients served in 1980. Because the increase in the state's population from 1980 to 1983 was 1.5%, the increase in clients served in these facilities during this time period cannot be entirely explained by a general population increase.

In 1984 there was a decrease, from 1983, in the total number of clients served. However, it should be noted that data in the Table for both 1983 and 1984 are incomplete.

Table 2 shows that the percentage of all mental health clients served who were served on an inpatient basis in these facilities also increased each year, from 8.5% in 1980 to 10.5% in 1984. This percentage also showed an overall increase from 1980 to 1983, for all age groups, except for clients 65 years of age and older.

TABLE 1

NUMBER OF CLIENTS RECEIVING INPATIENT MENTAL HEALTH SERVICES IN SPECIALTY HOSPITALS AND PSYCHIATRIC UNITS OF GENERAL HOSPITALS, BY AGE GROUP AND YEAR

YEAR	AGE 0-12 YEARS	AGE 13-17 YEARS	AGE 18-64 YEARS	AGE 65 YEARS AND OVER	AGE MISSING	TOTAL
1980	128 (2.3%)	465 (8.3%)	4,359 (77.5%)	352 (6.3%)	322 (5.7%)	5,626 (100.0%)
1981	131 (2.3%)	434 (7.7%)	4,453 (78.7%)	289 (5.1%)	348 (6.2%)	5,655 (100.0%)
1982	138 (2.4%)	469 (8.0%)	4,587 (78.2%)	323 (5.5%)	346 (5.9%)	5,863 (100.0%)
1983	152 (2.4%)	559 (8.9%)	4,843 (77.4%)	380 (6.1%)	321 (5.21%)	6,255 (100.0%)
1984	207 (3.5%)	589 (10.0%)	4,428 (73.9%)	358 (6.0%)	397 (6.6%)	5,989 (100.0%)

SOURCE: Wisconsin DHSS, Office of Mental Health, Transitional Information System.

TABLE 2

PERCENTAGE OF CLIENTS RECEIVING INPATIENT MENTAL HEALTH SERVICES IN SPECIALTY HOSPITALS AND PSYCHIATRIC UNITS OF GENERAL HOSPITALS, BY AGE GROUP AND YEAR

YEAR	AGE 0-12 YEARS	AGE 13-17 YEARS	AGE 18-64 YEARS	AGE 65 YEARS AND OVER	AGE MISSING	TOTAL
1980	3.4%	8.5%	9.3%	12.3%	4.6%	8.5%
1981	3.3%	7.9%	9.2%	9.3%	5.5%	8.4%
1982	3.8%	9.1%	10.0%	10.8%	6.4%	9.3%
1983	4.1%	10.3%	10.6%	12.3%	6.4%	10.0%
1984	6.1%	13.1%	10.8%	11.5%	8.0%	10.5%

SOURCE: Wisconsin DHSS, Office of Mental Health, Transitional Information System.

NOTE: The data given reflect the percentage of clients within a given age group receiving inpatient mental health services in specialty hospitals and psychiatric units of general hospitals versus other types of mental health services.

2. Nursing Homes

Tables 3 and 4, below, give the numbers of residents in nursing homes in the state with a primary diagnosis of mental illness and the percentage of nursing home residents with that diagnosis, according to age groups. Table 3 covers the years 1980 to 1984; Table 4 provides the information for 1985. The data given are the numbers and percentages as of December 31 of the years covered. A separate table is provided for 1985 because the DHSS's Center for Health Statistics began using different age groups for the data in 1985.

Tables 3 and 4 show that the total number of nursing home residents with a primary diagnosis of mental illness increased every year from 1980 to 1985, except 1983. The total number of such residents increased by 3,484 (from 6,376 to 9,860) over that period, which is a 55% increase. The major portion (74%) of this increase occurred between 1984 and 1985 when the number of nursing home residents with a primary diagnosis of mental illness increased by 2,587, or 20% (from 7,273 to 9,860).

From 1980 to 1985, there was also an overall increase in the percentage of nursing home residents with a primary diagnosis of mental illness, from 13.1% to 20.0%. The largest portion (77%) of this increase also occurred between 1984 and 1985 when the percentage went from 14.7% to 20.0%.

The increases between 1984 and 1985 are largely accounted for by large increases in the numbers and percentages of nursing home residents with a primary diagnosis of mental illness who are 75 years of age or older. The total number of such residents increased by 2,306 (from 3,762 to 6,068) or 61% between 1984 and 1985.

TABLE 3

NUMBER AND PERCENTAGE OF NURSING HOME RESIDENTS
WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS, BY AGE GROUP AND YEAR

YEAR	AGE UNDER 25 YEARS	AGE 25-54 YEARS	AGE 55-64 YEARS	AGE 65-74 YEARS	AGE 75-84 YEARS	AGE 85 YEARS AND OVER	TOTAL
1980	57 (0.1%)	827 (1.7%)	918 (1.9%)	1,578 (3.2%)	1,905 (3.9%)	1,091 (3.9%)	6,376 (13.1%)
1981	85 (0.2%)	852 (1.7%)	851 (1.7%)	1,647 (3.4%)	1,945 4.0%)	1,215 (2.5%)	6,619 (13.6%)
1982	75 (0.1%)	871 (1.8%)	850 (1.7%)	1,686 (3.5%)	2,079 (4.3%)	1,391 (2.9%)	6,952 (14.3%)
1983	84 (0.2%)	906 (1.8%)	786 (1.6%)	1,626 (3.3%)	2,003 (4.1%)	1,367 (2.8%)	6,772 (13.8%)
1984	74 (0.1%)	972 (2.0%)	836 (1.7%)	1,629 (3.3%)	2,205 (4.5%)	1,557 (3.1%)	7,273 (14.7%)

SOURCE: Wisconsin DHSS, Annual Survey of Nursing Homes, 1980-1984.

NOTE: The data given are for nursing home residents on December 31 of the indicated years.

TABLE 4

NUMBER AND PERCENTAGE OF NURSING HOME RESIDENTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS, BY AGE GROUP, DECEMBER 31, 1985

AGE	1985 NUMBER OF RESIDENTS	1985 PERCENTAGE OF RESIDENTS
AGE UNDER 21 YEARS	35	.07%
AGE 21-54 YEARS	974	2.0%
AGE 55-64 YEARS	887	1.8%
AGE 65-74 YEARS	1,898	3.9%
AGE 75-84 YEARS	3,174	6.6%
AGE 85-94 YEARS	2,541	5.3%
AGE 95 YEARS OR OVER	353	0.7%
TOTAL	9,860	20.0%

SOURCE: Wisconsin DHSS, Annual Survey of Nursing Homes, 1985.

D. PATIENTS' DIAGNOSTIC CATEGORIES

This section presents data on patients receiving inpatient mental health services according to major diagnostic categories. Data relating to diagnoses at specialty hospitals and psychiatric units of general hospitals is collected and analyzed by DHSS's Office of Mental Health. Data relating to diagnoses of patients in nursing homes is collected and analyzed by DHSS's Division of Health, Center for Health Statistics. The Office and Center use different diagnostic categories in preparing and presenting their data, making comparisons difficult.

1. Specialty Hospitals and Psychiatric Units in General Hospitals

Table 5, below, gives the numbers and percentages of patients receiving inpatient mental health services in specialty hospitals and psychiatric units in general hospitals according to diagnostic category, for the years 1980 through 1984. The diagnostic categories used in Table 5 are as follows:

a. Organic and nonorganic syndromes: Includes senile or presenile organic psychoses; transient organic psychoses, chronic organic psychoses and nonpsychotic organic syndromes.

b. Psychosis and Schizophrenia: Includes schizophrenic psychoses; affective psychoses; paranoid states; other nonorganic psychoses; and childhood psychoses.

c. Preadult disorders: Includes conduct disorders; preadult emotional disturbances; hyperkinetic syndromes; and specific delays in development.

d. Anxiety, depressive and personality disorders: Includes neurotic disorders; personality disorders; acute reactions to stress; adjustment reactions; and depressive disorders, not elsewhere classified.

e. Sexual deviations: Includes sexual deviations and disorders.

f. Psychosomatic and eating disorders: Includes physiological malfunctions; transient situational disturbances; and social maladjustments.

g. Social and adjustment problems.

h. No diagnosis or diagnosis deferred.

i. All other diagnosis codes, including mental retardation.

j. Diagnosis missing.

Data for 1985 is not included in Table 5, because it has not yet been processed by the Office of Mental Health. In addition, data for 1983 and 1984 represents only the data from the TIS, as explained in Section C, 1.

It should be noted that the total number of patients reported in Table 5 is higher than the number of patients in Table 1. According to the DHSS's Office of Mental Health, this difference is due to the fact that patients may have multiple diagnoses, which results in the patient being counted in more than one diagnostic category.

Table 5 shows that, for all of the years 1980 to 1984, more than 50% of the patients receiving inpatient mental health services in specialty hospitals or psychiatric units in general hospitals had a diagnosis in the psychosis and schizophrenic category. The number of such patients decreased slightly, from 1980 to 1984, from 3,829 to 3,810. Such patients also slightly, decreased as a percentage of all patients receiving inpatient mental health services, from 54.3% to 52.3%.

The next most prevalent diagnostic category was anxiety, depressive and personality disorders, with more than 20% of the patients in each of the years 1980 to 1984. This category shows a pattern of slight decrease over those years similar to that for psychosis and schizophrenia.

The remaining specific diagnostic categories each contain less than 4.0% of the patients.

TABLE 5

NUMBERS AND PERCENTAGES OF INPATIENTS IN SPECIALTY HOSPITALS AND PSYCHIATRIC UNITS OF GENERAL HOSPITALS, BY DIAGNOSTIC CATEGORY, 1980-1984

YEAR	ORGANIC AND NON-ORGANIC SYNDROMES	PSYCHOSES AND SCHIZOPHRENIA	PREADULT DISORDERS	ANXIETY, DEPRESSIVE AND PERSONALITY DISORDERS	SEXUAL DEVIATIONS	PSYCHOSOMATIC AND EATING DISORDERS	SOCIAL AND ADJUSTMENT PROBLEMS	NO OR DEFERRED DIAGNOSIS	ALL OTHER DIAGNOSES	DIAGNOSIS MISSING	TOTAL
1980	226 (3.2%)	3,829 (54.3%)	230 (3.3%)	1,577 (22.4%)	85 (1.2%)	55 (0.8%)	33 (0.5%)	241 (3.4%)	509 (7.2%)	263 (3.7%)	7,048 (100.0%)
1981	185 (2.8%)	3,581 (54.7%)	242 (3.7%)	1,535 (23.4%)	39 (0.6%)	52 (0.8%)	14 (0.2%)	185 (2.8%)	530 (8.1%)	195 (3.0%)	6,568 (100.0%)
1982	276 (3.7%)	3,937 (53.2%)	255 (3.4%)	1,782 (24.1%)	24 (0.3%)	65 (0.9%)	6 (0.1%)	345 (4.7%)	464 (6.3%)	250 (3.4%)	7,404 (100.0%)
1983	324 (4.2%)	4,051 (52.3%)	280 (3.6%)	1,698 (21.9%)	29 (0.4%)	104 (1.3%)	3 (0.0%)	570 (7.4%)	390 (5.0%)	296 (3.8%)	7,745 (100.0%)
1984	260 (3.6%)	3,810 (52.3%)	285 (3.9%)	1,533 21.0%)	9 (0.1%)	114 (1.6%)	4 (0.1%)	546 (7.5%)	384 (5.3%)	341 (4.7%)	7,286 (100.0%)

SOURCE: Wisconsin DHSS, Office of Mental Health, Transitional Information System.

2. Nursing Homes

Table 6, below, gives the numbers and percentages of patients in nursing homes with a primary diagnosis of mental illness, according to diagnostic category, as of December 31, 1985. Data for 1980 to 1984 are not available. Table 7, below, breaks down diagnostic category information according to age group.

The diagnostic categories used by the Center for Health Statistics and in Tables 6 and 7 are as follows:

a. Organic/psychotic diagnoses: Includes senile dementia; alcoholic psychoses; drug psychoses; transient organic psychotic conditions; and other chronic organic psychotic conditions.

b. Organic/non-psychotic diagnoses: Includes specific non-psychotic mental disorders due to organic brain damage.

c. Non-organic/psychotic diagnoses: Includes schizophrenic disorders; affective psychoses; paranoid states; and other non-organic psychoses.

d. Non-organic/non-psychotic diagnoses: Includes neurotic disorders; personality disorders; sexual deviations and disorders; physiological malfunctions arising from mental factors; special symptoms or syndromes, not elsewhere classified; acute reactions to stress; adjustment reaction; depressive disorders, not elsewhere classified; disturbances of conduct, not elsewhere classified; disturbances of emotions specific to childhood and adolescents; hyperkinetic syndromes of childhood; and psychic factors associated with diseases classified elsewhere.

Table 6 shows that, on December 31, 1985, 92% of the nursing home residents who had a primary diagnosis of mental illness fit into the three diagnostic categories of organic/psychotic, organic/non-psychotic or non-organic/psychotic, with approximately 30% in each of the three categories. The remaining 8% of these nursing homes residents were in the non-organic/non-psychotic category.

Table 7 breaks down the diagnostic category information according to age group. It shows, for example, that persons in the 21- to 54-year old age group make up a higher percentage (24.1%) of the patients in the non-organic/psychotic diagnostic category than any other category. This age group accounts for 15.8% of the patients in the non-organic/non-psychotic category and less than 4% of each of the two organic categories.

Table 7 also shows, for example, that persons 75 years of age and older tend to constitute larger percentages of the two organic categories than they constitute of the two non-organic categories. An exception is the relatively high percentage of the non-organic/non-psychotic category made up of persons 75 to 84 years of age.

TABLE 6

NUMBER AND PERCENTAGE OF NURSING HOME RESIDENTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS, BY DIAGNOSTIC CATEGORY, DECEMBER 31, 1985

DIAGNOSTIC CATEGORY	1985 NUMBER OF RESIDENTS	1985 PERCENTAGE OF RESIDENTS
ORGANIC/ PSYCHOTIC	3,186	32.2%
ORGANIC/ NON-PSYCHOTIC	2,814	28.5%
NON-ORGANIC/ PSYCHOTIC	3,087	31.3%
NON-ORGANIC/ NON-PSYCHOTIC	784	8.0%
TOTAL	9,871	100.0%

SOURCE: Wisconsin DHSS, Office of Health, Center for Health Statistics.

TABLE 7

NUMBER AND PERCENTAGE OF NURSING HOME RESIDENTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS, BY AGE AND DIAGNOSTIC CATEGORY, DECEMBER 31, 1985

DIAGNOSTIC CATEGORY	AGE UNDER 21 YEARS	AGE 21-54 YEARS	AGE 55-64 YEARS	AGE 65-74 YEARS	AGE 75-84 YEARS	AGE 85-94 YEARS	AGE 95 YEARS OR OVER	TOTAL
ORGANIC/ PSYCHOTIC	0 (0.0%)	107 (3.4%)	197 (6.2%)	544 (17.1%)	1,173 (36.8%)	1,026 (32.2%)	139 (4.4%)	3,186 (100.0%)
ORGANIC/ NON-PSYCHOTIC	2 (0.07%)	104 (3.7%)	98 (3.5%)	374 (13.2%)	1,042 (37.0%)	1,032 (36.7%)	162 (5.8%)	2,814 (100.0%)
NON-ORGANIC/ PSYCHOTIC	20 (0.06%)	743 (24.1%)	538 (17.4%)	786 (25.5%)	652 (21.1%)	315 (10.2%)	33 (1.1%)	3,087 (100.0%)
NON-ORGANIC/ NON-PSYCHOTIC	12 (1.5%)	124 (15.8%)	51 (6.5%)	163 (20.8%)	271 (34.6%)	146 (18.6%)	17 (2.2%)	784 (100.0%)

SOURCE: Wisconsin DHSS, Office of Health, Center for Health Statistics.

E. PATIENTS' LENGTHS-OF-STAYS

This section provides data on the lengths-of-stays of patients at the various types of inpatient mental health facilities. In Tables 8 and 9, below, the term "short-term beds" refers to beds which are available primarily for patients experiencing acute symptoms of mental illness who are in need of diagnosis and evaluation, treatment, or both. The term "long-term beds" refers to beds which are available primarily for patients with chronic mental illness who are in need of a long-range treatment program.

Table 8 gives the average lengths-of-stays at specialty hospitals and psychiatric units in general hospitals for patients receiving inpatient mental health services. Length-of-stay information is not available for nursing homes. Because it is believed to affect facilities' average lengths-of-stays, Table 8 also gives the numbers of short-term and long-term beds available in specialty hospitals, psychiatric units in general hospitals and nursing homes. The numbers given for nursing home beds include beds for patients who do not have a primary diagnosis of mental illness, as well as those who do. Table 8 covers calendar year 1982.

Table 9 gives patient average length-of-stay information for specialty hospitals, according to short-term beds only and long-term and short-term beds combined. Only specialty hospitals are included in Table 9 since only specialty hospitals have both long-term and short-term beds.

The information is provided separately, in Table 9, for the state's two mental health institutes and for other specialty hospitals; a combined average is also given. The information covers patients at the hospitals during calendar year 1982.

As stated above, length-of-stay data for nursing homes is not available and, therefore, not presented in Table 8. However, according to a 1984 DHSS report, Overview of the Mental Health Inpatient/Residential Delivery System, the average length-of-stay in nursing homes is believed to exceed the average length-of-stay at other types of inpatient mental health facilities.

Table 8 shows that the average length-of-stay is longer in specialty hospitals (22.7 days), which have both long-term and short-term beds, than in psychiatric units in general hospitals (14.6 days), which have only short-term beds. However, Table 9 shows a wide variation in average lengths-of-stays between the state's mental health institutes and other specialty hospitals. For specialty hospitals other than the institutes, the average length-of-stay for long-term and short-term beds combined (14.5 days) is substantially the same as the average length-of-stay (14.6 days), shown in Table 8, for psychiatric units in general hospitals.

Table 9 also shows that the average length-of-stay for short-term beds only in specialty hospitals other than the institutes is shorter (11.2 days) than for the psychiatric units in general hospitals (14.6 days).

For the state's two mental health institutes, Table 9 shows that the average lengths-of-stays for long-term and short-term beds combined (142.5 days) and for short-term beds only (142.7 days) are substantially the same.

TABLE 8

AVERAGE LENGTHS-OF-STAYS IN SPECIALTY HOSPITALS, PSYCHIATRIC UNITS OF GENERAL HOSPITALS AND NURSING HOMES, 1982

TYPE OF FACILITY	SPECIALTY HOSPITALS	PSYCHIATRIC UNITS IN GENERAL HOSPITALS	NURSING HOMES
Number of Beds	1,193	969	53,817 1/
Short Term	837	969	0
Long Term	356	0	53,817
Average Lengths-of-Stays (Days)	22.7	14.6	Not Available

1/ Includes beds for patients who do not have a diagnosis of mental illness, as well as those who do.

SOURCE: An Overview of the Mental Health Inpatient/Residential Delivery System, DHSS Bureau of Evaluation, Division of Policy and Budget, May 31, 1984.

TABLE 9

AVERAGE LENGTHS-OF-STAYS AT SPECIALTY HOSPITALS, FOR SHORT-TERM BEDS AND LONG-TERM AND SHORT-TERM BEDS COMBINED, 1982

FACILITY	AVERAGE LENGTHS-OF-STAYS (IN DAYS)	
	LONG- AND SHORT-TERM BEDS	SHORT-TERM BEDS ONLY
State Mental Health Institutes	142.5	142.7
Specialty Hospitals Excluding State Institutes	14.5	11.2
Specialty Hospitals Including Mental Health Institutes	22.7	17.4

SOURCE: An Overview of the Mental Health Inpatient/Residential Delivery System, DHSS Bureau of Evaluation, Division of Policy and Budget, May 31, 1984.

F. COUNTY EXPENDITURES FOR INPATIENT SERVICES

Appendix B summarizes expenditures for inpatient mental health services made by each of the 56 county mental health boards for calendar years 1983 and 1984. Funding sources are discussed in Part IV.

Appendix B includes for each board: (1) the counties under the board's jurisdiction; (2) the dollar amounts of the board's expenditures for inpatient services in 1983 and 1984; and (3) the percentage of the board's total expenditures represented by the inpatient expenditures.

Appendix B shows substantial differences among county mental health boards in their expenditure levels for inpatient mental health services and the percentage of the total expenditures which are made for inpatient mental health services. For example, in 1983, Dane County expended $1,188,319 for inpatient mental health services; this was 21.7% of the board's total mental health service expenditures. Brown County expended $3,653,534 in 1983 on inpatient mental health services; this was 72.3% of their total mental health service expenditures. In 1984, Dane County expended $1,683,595, or 27.0% of its total expenditures, for inpatient services. Brown County expended $3,800,968, or 70.7% of its total expenditures for inpatient services in 1984.

In reviewing Appendix B, it is important to note that for small counties, a change by even one in the number of clients served on an inpatient basis may cause a large change in the percentage of total expenditures allocated to inpatient services. Also, a relatively small change in the board's total budget, while the dollar expenditure for inpatient services remains the same, could cause a large change in the percentage of total expenditures allocated for inpatient services.

PART III

OUTPATIENT, RESIDENTIAL AND OTHER COMMUNITY-BASED MENTAL HEALTH SERVICES

In this Staff Brief, community-based mental health services refers to mental health services, other than the inpatient mental health services described in Part II, provided by county mental health boards to persons residing in the board's jurisdiction. Persons with mental illnesses may be involuntarily committed to receive community-based mental health services, pursuant to s. 51.20 (13), Stats.; may be ordered by a court to receive community-based services under s. 55.05, Stats., relating to protective placement; or may receive services voluntarily.

This Part of the Staff Brief discusses: (a) the types of community-based mental health services and programs; (b) the characteristics of persons receiving community-based mental health services; and (c) community-based mental health service expenditures.

A. SERVICES AND PROGRAMS

As described in Part I, C, the statutes vest in the counties the primary responsibility for providing services to mentally ill residents of the county and emphasize the use of the least restrictive treatment alternative. The statutes direct county mental health boards to make available prevention, assessment, diagnosis and treatment services to the extent federal, state and county matching funds are available. The statutes authorize the boards to provide other services, at their option.

This section describes the types of community-based mental health services provided by county mental health boards.

1. Required Services

To fulfill statutory requirements, county mental health boards provide community-based mental health services in each of the categories described below. These service categories were developed by DHSS for reporting purposes. The actual form of services offered varies from county to county. The service categories are:

a. Prevention Programs

Prevention programs are activities, including public education and information distribution, directed at the general population or specific target population, and are designed to increase the level of knowledge about mental illness, developmental disabilities and alcohol and other drug abuse problems; to change attitudes; and to attempt to assist persons before problems develop into disabilities needing further mental health services.

b. Outpatient Care and Treatment Services

Outpatient care and treatment programs are nonresidental services, provided intermittently, to attempt to ameliorate or remove a disability and to restore the individual to more effective functioning. Outpatient care may occur on a single contact basis or on a schedule of routine, short visits over an extended period of time. Outpatient care includes evaluation and diagnosis, medical services, counseling, rehabilitation and aftercare.

c. Residential Facilities and Services

(i) Transitional and community living programs. These programs are offered to persons living in minimally supervised, non-medical facilities in the community. The programs offer service for not less than 72 hours per week to persons with problems related to mental illness, in order to facilitate their return to independent living. In addition to room and board, these programs provide services such as counseling, recreation, social skills development and daily living skills development for a portion of a 24-hour day to persons.

(ii) Extended care programs. These programs are treatment-oriented living facility services where supervision, training and personal care are available and access to nursing and medical care is ensured for 24-hours each day. These programs emphasize self-care, social skills training, treatment and recreation for dependent persons with mental disabilities who are in need of extended care.

d. Outpatient Emergency Care Services

Outpatient emergency care services encompass emergencies such as emotional crises, attempted suicides, family crises and other emergencies. Services include the examination of individuals and, if needed, transportation to an emergency room of a general hospital for medical treatment. These services are distinguished from inpatient emergency care services, which were discussed in Part II.

e. Day Services

These services are nonresidential, comprehensive coordinated activities to enhance maturation and social development and to alleviate mental disabilities. Day services provide for the delivery of services on a routine basis to clients for a scheduled portion of a 24-hour day. Day services are divided into two categories:

(i) Medical day services. These services include supervised personal care, treatment and psychotherapy in a medically-supervised setting.

(ii) Non-medical day services. These services include counseling, training and recreation in a non-medically-supervised setting.

f. Sheltered Employment Programs

These programs provide vocational evaluation, training and noncompetitive employment for persons with problems related to mental disabilities. Sheltered employment occupies up to a full working day. Sheltered employment may be provided in a workshop, at home or in a regular work environment.

g. Community Support Program

As described in Part I, B, 2, the CSP is a care and treatment system which provides a variety of services to persons with chronic mental illness through an identified treatment program and staff. The goal of the CSP is to enable persons with chronic mental illness to function in their communities. The CSP attempts to identify persons with chronic mental illness to encourage them to participate in the program, as opposed to requiring the client to contact the program to receive services.

The services provided by the CSP to persons with chronic mental illness are as follows:

(i) Continuity of care through coordinated case management.

(ii) Clinical symptom management.

(iii) Medication prescription and monitoring.

(iv) Vocational and employment services, or assistance in planning a daily structure.

(v) Assistance in establishing a living situation.

(vi) Teaching daily living activities.

(vii) Supportive counseling and family education.

(viii) Social skills development, including recreation and leisure time activities.

(ix) Crisis intervention services.

2. Optional Services

As described in Part I, C, county mental health boards may participate in the COP. Under the COP, persons who are about to enter nursing homes or state developmental disability centers are screened to determine if they could be kept in the community if adequate support services were provided. The COP serves five targeted groups at risk of entering such facilities. Persons with chronic mental illness are one of these targeted groups.

Components of the COP include:

a. The screening process, which attempts to determine if the individual could live in the community if provided with adequate available support services.

b. Supplementary funding to existing county agencies to enable them to provide support services to COP clients remaining in the community.

c. Coordination of services provided to COP clients by separate agencies.

The COP is administered on a state level by the DHSS's Office of Program Initiatives in the Division of Community Services and on a local level by the counties. The DHSS is responsible for establishing general COP guidelines and for reviewing and either approving or disapproving county COP plans.

A lead county agency, either the county social services agency or mental health board, must be selected to administer the COP at the county level. A long-term support planning committee, composed of representatives from the five targeted groups, as well as elected officials and county agency representatives, is responsible for preparing the county COP plan. Both the lead agency and the long-term support planning committee are designated by the county board of supervisors.

As of calendar year 1985, 59 counties had elected to participate in COP.

B. NUMBERS OF CLIENTS SERVED

This section provides data on the distribution of clients among the community-based mental health service categories. Table 10, below, gives, for the years 1980 through 1984, for each service category: (1) the numbers of persons who received the services, by age group; and (2) the percentage of the total number of clients served who were served under that service category. Service categories for which data are provided include: (1) outpatient emergency care; (2) outpatient care and treatment; (3) medical and non-medical day services; (4) sheltered employment; and (5) residential services.

Because the data in Table 10 was provided by the DHSS's Office of Mental Health's TIS, the same caveats are applicable to this data as were described in Part II, C, 1.

The percentages in Table 10 do not add up to 100% because the entire range of mental health services provided by community mental health boards is not included in the Table. Clients served in extended care programs and inpatient programs were not included. [Clients served in inpatient mental health services are included in Table 1, in Part II.]

Table 10 shows that, for the years 1980 to 1984, for all age groups, the largest percentage of clients was served in outpatient care and treatment programs, with clients in the two youngest age groups, 0 to 12 years and 13 to 17 years, receiving a higher percentage of their services in that category than clients in the other age group.

TABLE 10

NUMBER AND PERCENTAGE OF CLIENTS RECEIVING COMMUNITY-BASED MENTAL HEALTH SERVICES, BY SERVICE CATEGORY, AGE AND YEAR

	PROGRAM TYPE											
					DAY SERVICES							
CLIENT'S AGE	OUTPATIENT EMERGENCY CARE		OUTPATIENT CARE AND TREATMENT		MEDICAL		NON-MEDICAL		SHELTERED EMPLOYMENT		RESIDENTIAL SERVICES	
0-12 Years	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1980	22	0.6%	3,370	90.3%	60	1.6%	112	3.0%	0	0.0%	11	0.3%
1981	28	0.7%	3,714	92.2%	46	1.1%	57	1.4%	4	0.1%	13	0.3%
1982	34	0.9%	3,322	91.6%	57	1.6%	40	1.1%	3	0.1%	22	0.6%
1983	24	0.6%	3,429	91.7%	58	1.6%	36	1.0%	2	0.1%	26	0.7%
1984	44	1.3%	30,042	89.0%	74	2.2%	42	1.2%	1	0.0%	3	0.1%
13-17 Years												
1980	171	3.1%	4,452	80.9%	48	0.9%	40	0.7%	8	0.1%	10	0.2%
1981	161	2.9%	4,518	82.7%	49	0.9%	22	0.4%	6	0.1%	6	0.1%
1982	208	4.0%	4,178	80.8%	46	0.9%	22	0.4%	6	0.1%	13	0.3%
1983	196	3.6%	4,430	81.9%	40	0.7%	14	0.3%	2	0.0%	5	0.1%
1984	217	4.8%	3,563	78.0%	36	0.8%	14	0.3%	4	0.1%	1	0.0%
18-64 Years												
1980	3,117	6.7%	29,178	62.3%	2,294	4.9%	1,623	3.5%	1,278	2.7%	1,177	2.5%
1981	2,851	5.9%	31,484	64.7%	2,307	4.8%	1,655	3.4%	1,345	2.8%	1,371	2.8%
1982	2,962	6.4%	28,927	62.9%	2,047	4.5%	1,863	4.1%	1,336	2.9%	1,250	2.7%
1983	2,885	6.3%	28,193	62.0%	2,032	4.5%	1,788	4.0%	1,343	3.0%	1,182	2.6%
1984	3,098	7.6%	24,828	60.7%	1,900	4.6%	2,045	5.0%	1,327	3.2%	1,111	2.7%
65 Years and Older												
1980	178	6.2%	1,633	57.1%	159	5.6%	235	8.2%	50	1.7%	27	0.9%
1981	157	5.0%	2,089	66.5%	161	5.2%	210	6.7%	52	1.7%	48	1.5%
1982	107	3.6%	2,021	67.8%	119	4.0%	185	6.2%	47	1.6%	40	1.3%
1983	125	4.1%	2,063	68.9%	81	2.6%	167	5.4%	55	1.8%	37	1.2%
1984	127	4.1%	2,127	68.2%	74	2.4%	189	6.1%	62	2.0%	35	1.1%
Age Missing												
1980	69	1.0%	4,851	69.9%	313	4.5%	585	8.1%	459	6.6%	136	2.0%
1981	116	1.8%	4,210	67.1%	261	4.2%	509	8.1%	414	6.6%	110	1.8%
1982	66	1.2%	3,995	72.2%	199	3.7%	328	6.0%	237	4.4%	85	1.6%
1983	58	1.2%	3,575	71.5%	138	2.8%	307	6.1%	217	4.3%	84	1.7%
1984	58	1.2%	3,494	70.8%	118	2.4%	334	6.7%	185	3.7%	85	1.7%
TOTALS												
1980	3,555	5.4%	43,484	66.0%	2,874	4.4%	2,575	3.9%	1,793	2.7%	1,361	2.1%
1981	3,313	4.9%	45,855	68.0%	2,824	4.2%	2,453	3.6%	1,821	2.7%	1,548	2.3%
1982	3,377	5.3%	42,351	67.0%	2,488	3.9%	2,436	3.9%	1,629	2.6%	1,410	2.2%
1983	3,288	5.2%	41,690	66.5%	2,349	3.7%	2,323	3.7%	1,619	2.6%	1,334	2.1%
1984	3,544	6.2%	37,054	65.1%	2,202	3.9%	2,624	4.6%	1,579	2.8%	1,235	2.2%

NOTE: Percentages do not equal 100% because not all mental health programs are included in the Table.

SOURCE: Department of Health and Social Services Office of Mental Health: Transitional Information System (TIS).

C. CLIENT DIAGNOSTIC CATEGORIES

This section provides data on persons receiving outpatient mental health care and treatment according to the major diagnostic categories described in Part II, D, 1. Diagnoses are available only for persons receiving outpatient program services and, thus, Table 11, below, gives information only for clients receiving that category of service. Table 11 gives the numbers and percentages of persons receiving outpatient services in each diagnostic category, for each year from 1980 to 1984. The data presented in Table 11 is from the DHSS's Office of Mental Health's TIS. Therefore, the caveats noted in Part II, C, 1, are also applicable here.

Table 11 shows that, from 1980 to 1984, approximately 50% of the total number of clients who received outpatient care and treatment had a diagnosis from the anxiety, depressive and personality disorders category.

The next most consistently prevalent diagnosis category was psychosis and schizophrenic, which accounted for from 11.7% (in 1980) to 15.5% (in 1984) of the total number of clients served during those years. The next two most prevalent diagnoses were preadult disorders, which increased from 8.5% in 1980 to 10.4% in 1984; and social and adjustment problems, which decreased from 15.5% in 1980 to 5.8% in 1984.

The total number of clients receiving outpatient care and treatment reported in Tables 10 and 11 are different because, according to DHSS's Office of Mental Health, clients in Table 10 are the total clients being served in a given year, some of whom may have also received services in prior years. Clients in Table 11 are only the new clients for a given year for whom admission forms were completed and diagnoses assigned.

TABLE 11

NUMBERS AND PERCENTAGES OF PERSONS RECEIVING OUTPATIENT MENTAL HEALTH CARE AND TREATMENT IN EACH DIAGNOSTIC CATEGORY, 1980-1984

YEAR	ORGANIC AND NON-ORGANIC SYNDROMES	PSYCHOSES AND SCHIZOPHRENIA	PREADULT DISORDERS	ANXIETY, DEPRESSIVE AND PERSONALITY DISORDERS	SEXUAL DEVIATIONS	PSYCHOSOMATIC AND EATING DISORDERS	SOCIAL AND ADJUSTMENT PROBLEMS	NO OR DEFERRED DIAGNOSIS	ALL OTHER DIAGNOSES	DIAGNOSIS MISSING	TOTAL
1980	395 (1.3%)	3,464 (11.7%)	2,495 (8.5%)	14,464 (49.0%)	154 (0.5%)	533 (1.8%)	4,574 (15.5%)	1,365 (4.6%)	1,295 (4.4%)	751 (2.5%)	24,490 (100.0%)
1981	464 (1.6%)	3,636 (12.6%)	2,742 (9.5%)	14,876 (51.4%)	192 (0.7%)	431 (1.5%)	3,260 (11.3%)	1,572 (5.4%)	1,311 (4.5%)	478 (1.7%)	28,962 (100.0%)
1982	557 (1.9%)	4,194 14.6%)	2,756 (9.6%)	14,096 (49.1%)	176 (0.6%)	337 (1.2%)	2,730 (9.5%)	1,752 (6.1%)	1,379 (4.8%)	714 (2.5%)	28,691 (100.0%)
1983	502 (1.8%)	3,978 (14.6%)	2,868 (10.5%)	14,003 (51.4%)	170 (0.6%)	283 (1.0%)	1,974 (7.3%)	1,623 (6.0%)	1,336 (4.9%)	484 (1.8%)	27,221 (100.0%)
1984	409 (2.1%)	3,015 (15.5%)	2,027 (10.4%)	9,835 (50.7%)	110 (0.6%)	218 (1.1%)	1,120 (5.8%)	1,416 (7.3%)	840 (4.3%)	423 (2.2%)	19,413 (100.0%)

SOURCE: Wisconsin DHSS, Office of Mental Health, Transitional Information Systems.

D. COUNTY EXPENDITURES

This section provides data on county expenditures for certain community-based mental health services. Funding sources are discussed in Part IV.

Appendix C shows the expenditures for selected community-based mental health services programs for each of the 56 county mental health boards during calendar year 1983. Appendix D gives the same information for calendar year 1984.

Appendices C and D provide expenditure data for three categories of services: outpatient services, sheltered employment and residential services. The "outpatient services" category includes outpatient care and treatment, outpatient emergency services and medical and non-medical day services. The Appendices also give the percentage of the board's total mental health budget expended under each category.

Appendices C and D show a wide variation in county mental health boards' allocations of expenditures among these categories. As was done for inpatient expenditures in Part II of this Staff Brief, the county mental health boards of Brown and Dane Counties will be used as examples.

Appendix C shows that, for calendar year 1983, Brown County spent $996,126 (19.7% of its total mental health expenditures) on outpatient programs; $175,432 (3.5%) on sheltered employment programs; and $35,575 (0.7%) on residential programs.

In 1983, Dane County made substantially higher percentages of its total expenditures in each of these categories. Dane County spent $2,144,121 (39.1% of its total mental health expenditures) on outpatient programs; $450,202 (8.2%) on sheltered employment programs; and $875,280 (15.9%) on residential programs.

Appendix D shows similar results for calendar year 1984. In 1984, Brown County expended $1,143,029 (21.3%) on outpatient programs; $207,512 (3.9%) on sheltered employment programs; and $50,379 (0.9%) on residential programs.

In 1984, Dane County spent $2,314,817 (37.1%) on outpatient programs; $481,221 (7.7%) on sheltered employment programs; and $932,784 (15.0% on residential programs.

The percentages in Appendices C and D do not add to 100%, because not all mental health services are listed in these Appendices. Expenditures for prevention, education, training and other services, including inpatient services, were not included. Expenditures for inpatient services are located in Appendix B.

PART IV

FUNDING OF MENTAL HEALTH SERVICES

This Part describes funding of county expenditures for mental health services in Wisconsin. County mental health boards are responsible for providing and paying for mental health services provided to residents within the board's jurisdiction. Funding for these services is provided primarily through community aids funds, county matching funds, Medical Assistance, private insurance reimbursements and client fees. A county mental health board will generally seek reimbursement from Medical Assistance, private insurance and client fees before paying for mental health services from its community aids and county matching funds. Services provided through the COP are funded through a combination of federal and state funds and client fees.

This Part also describes funding for the state's two mental health institutes.

A. COMMUNITY AIDS FUNDS

Community aids funds are a combination of state and federal funds which are distributed by DHSS to the counties. The state's share of community aids funds comes from GPR; the federal share consists primarily of federal block grant moneys allocated until Title XX of the Social Security Act. The proportion of state funds to federal funds in the community aids allocation for the 1985-87 biennium is approximately 2/3rds state funds to 1/3rd federal funds.

Community aids funds for 1985-86 and 1986-87 are shown in Table 12.

Seventeen counties receive their community aids allocation in one consolidated allocation for both social and mental health services. The remaining 55 counties receive separate allocations for their social service boards and mental health boards. The community aids funds for both social services and mental health services are included in Table 12.

TABLE 12

COMMUNITY AIDS FUNDS, 1985-86 AND 1986-87

YEAR	STATE (GPR)	FEDERAL (FED)	TOTAL
1985-86	$124,867,400	$65,903,300	$189,770,700
1986-87	$143,712,200	$62,896,400	$206,608,600
Total 1985-87 Biennium	$268,579,600	$128,799,700	$396,379,300

SOURCE: Section 20.435 (4) (b), Stats., as affected by 1985 Wisconsin Act 29.

Most of the community aids funds (86%), are allocated to the counties without any designation as to how funds should be allocated among programs, but counties must provide statutorily-required services. The remainder (14%) of the community aids funds are distributed to the counties for specified programs.

The CSP is funded through the community aids allocation. Part of the funding for the CSP comes from the basic 86% allocation. In addition, part of the 14% allocated for specific programs is earmarked for the CSP. The funds earmarked for the CSP are combined for services to both the chronically mentally ill and developmentally disabled. For the 1985-87 biennium, the amount earmarked for the CSP is $5,851,900.

Finally, part of the community aids allocation is designated as a CSP supplement for the chronically mentally ill. For the 1985-87 biennium, the CSP supplement is $2,500,000.

B. COUNTY MATCHING FUNDS

Counties are required to provide a match to the community aids funds for certain programs in an amount which equals 9% of the county's community aids allocation. Exceptions allow counties to expend funds for the following items without providing the 9% match: (1) community-based residential facility admissions; (2) family support programs (which are provided primarily to families of children with developmental disabilities); (3) nursing home relocation funds; and (4) emergency funds, allocated to counties as needed to cover unanticipated costs [s. 49.52 (1) (d), Stats., as affected by 1985 Wisconsin Acts 29 and 176].

C. COUNTY FEES

In order to receive community aid funds, counties must charge fees for certain mental health services using a fee structure established by the DHSS by rule. Fees are based on the client's ability to pay. Appendix E shows the services for which fees must be charged.

D. MEDICAL ASSISTANCE

The Medical Assistance program, which provides reimbursements for certain mental health services provided to clients who meet Medical Assistance eligibility requirements, is operated and funded jointly by the federal government and the states.

The federal government funds approximately 57% of Wisconsin's Medical Assistance costs; the state funds approximately 43% of the costs. Both the federal and state governments establish rules governing Medical Assistance participation and reimbursements. In order to receive federal Medical Assistance funds, states must comply with federal program guidelines. States may choose to provide additional funding for services not covered by the federal Medical Assistance program [ss. 49.43 to 49.497, Stats.]. Medical Assistance reimbursements for mental health services are available as described in this section.

1. Inpatient Programs

a. Specialty Hospitals

Except as described below, Medical Assistance funds are not available to reimburse counties for inpatient mental health services provided at speciality hospitals (state-operated mental health institutes, county-operated mental hospitals and privately-operated psychiatric hospitals) [s. 49.46 (2) (a) 4 a and c, Stats., as affected by 1985 Wisconsin Act 29].

Mental health services provided for inpatients in specialty hospitals who: (1) are less than 21 years old; or (2) are under 22 years of age and were receiving inpatient mental health services immediately prior to reaching age 21; or (3) are over 65 years of age, are reimbursable under the Medical Assistance program [s. 49.46 (2) (b) 6 e, Stats.]

Wisconsin had been providing Medical Assistance coverage for inpatient mental health services provided in specialty hospital facilities to patients who were 22 to 64 years of age, for the calendar month in which the patients were admitted to the facility. However, 1985 Wisconsin Act 29 repealed this provision.

b. Psychiatric Units in General Hospitals

Medical Assistance reimbursement is provided for patients receiving inpatient mental health services in psychiatric units in general hospitals.

c. Nursing Homes

Services provided to persons receiving inpatient mental health services in nursing homes are reimbursed under the Medical Assistance program. However, according to DHSS staff, the federal government may, in the near future, cease paying its share (57%) of these costs. The federal government will stop making the payments, if it determines that nursing homes providing these services are actually "institutes for mental diseases," for which federal reimbursement is unavailable under the Medical Assistance program.

2. Community-Based Mental Health Programs

a. Outpatient Psychotherapy Services

Outpatient psychotherapy services provided by county mental health boards may be reimbursed under Medical Assistance when prescribed by a physician, if the provider and the services meet requirements set out in DHSS administrative rules. [See s. HSS 107.13 (2) (a), Wis. Adm. Code.]

b. Day Treatment and Day Hospital Services

Day treatment or day hospital services provided by county mental health boards may be reimbursed under Medical Assistance when prescribed by a physician, if the provider and the services meet requirements set forth in DHSS rules [s. HSS 107.13 (4) (a), Wis. Adm. Code].

E. COMMUNITY OPTIONS PROGRAM

The COP is funded through a combination of GPR and federal appropriations. For the 1985-87 biennium, $42,836,800 GPR and $479,000 FED, for a total of $43,315,800, was appropriated to COP.

The COP program also receives revenue from client fees. A client may be eligible to receive COP services without payment, if he or she is: (1) currently eligible for Medical Assistance; or (2) would become eligible for Medical Assistance within six months if he or she entered a nursing home. [Clients in the second category may be required to make some cost-sharing payments.] Clients ineligible for Medical Assistance are required to pay 100% of the cost of COP services provided to them.

F. MENTAL HEALTH INSTITUTES

The state provides GPR for the operation of Mendota and Winnebago Mental Health Institutes. Also, county mental health boards must pay for inpatient admissions to these institutes for clients from their jurisdictions.

For the 1985-87 biennium, $44,991,100 GPR was appropriated to Mendota Mental Health Institute; and $37,742,200 GPR was appropriated to the Winnebago Mental Health Institute.

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APPENDIX A

COUNTY MENTAL HEALTH BOARDS CONVERTING FROM DHSS TRANSITIONAL INFORMATION SYSTEM (TIS) TO CLIENT SERVICES INFORMATION SYSTEM (CSIS) IN 1983 AND 1984

COUNTY MENTAL HEALTH BOARDS CONVERTING FROM DHSS TRANSITIONAL INFORMATION SYSTEM (TIS) TO CLIENT SERVICES INFORMATION SYSTEM (CSIS) IN 1983 AND 1984

1983

Columbia

1984

Ashland/Iron/Price
Clark
Crawford
Dodge
Door
Douglas
Florence
Green Lake
Kewaunee
Marquette
Menominee
Monroe
Pepin
Pierce
Racine
St. Croix
Sawyer
Shawano/Waupaca
Taylor
Washington
Waukesha

APPENDIX B

EXPENDITURES FOR INPATIENT MENTAL HEALTH SERVICES BY COUNTY MENTAL HEALTH BOARDS, FOR CALENDAR YEARS 1983 AND 1984

EXPENDITURES FOR INPATIENT MENTAL HEALTH SERVICES BY COUNTY MENTAL HEALTH BOARDS, FOR CALENDAR YEARS 1983 AND 1984

COUNTY	INPATIENT EXPENDITURES		INPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	
	1983	1984	1983	1984
Adams	112,863	68,205	46.7%	29.2%
Ashland/Iron/ Price	299,518	347,369	51.2%	55.9%
Barron/Burnett/ Polk/Rusk/ Washburn	767,531	879,552	48.4%	50.1%
Bayfield	32,010.05	23,873	23.9%	17.6%
Brown	3,653,534	3,800,968	72.3%	70.7%
Buffalo/Jackson/ Trempeleau	480,895	505,239	51.2%	49.2%
Calumet	207,132.97	204,148	52.2%	45.4%
Chippewa	210,763	84,557	34.2%	17.5%
Clark	205,934	610,336	52.0%	48.5%
Columbia	256,248	198,415	42.8%	36.0%
Crawford	129,878	90,374	36.0%	26.4%
Dane	1,188,319	1,683,595	21.7%	27.0%
Dodge	299,212	537,932	30.5%	39.4%
Door	299,881	616,324	74.2%	66.7%
Douglas	706,297	802,496	60.3%	57.7%
Dunn	273,248.01	373,694	53.8%	46.7%
Eau Claire	661,510	581,439	45.1%	41.8%
Florence	11,484	13,641	19.3%	30.3%
Fond Du Lac	680,460.31	660,470	43.5%	42.3%
Forest/Oneida Vilas.	459,184	478,493	48.1%	46.3%
Grant/Iowa	530,734	----	50.3%	----
Green	179,450	124,044	37.2%	22.8%
Green Lake	34,134	44,450	19.3%	67.6%
Jefferson	326,187	186,245	32.8%	22.5%
Juneau/Richland/ Sauk	913,809	1,146,310	42.8%	46.4%
Kenosha	1,643,040	1,743,704	63.3%	62.4%
Kewaunee	40,175	81,113	23.4%	30.3%
La Crosse	389,102	534,551	31.9%	37.5%
Lafayette	24,287	18,718	12.5%	10.8%
Langlade/Lincoln Marathon	2,078,850	1,653,128	43.6%	43.7%

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APPENDIX B TABLE (CONTINUED)

EXPENDITURES FOR INPATIENT MENTAL HEALTH SERVICES BY COUNTY MENTAL HEALTH BOARDS, FOR CALENDAR YEARS 1983 AND 1984

COUNTY	INPATIENT EXPENDITURES		INPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	
	1983	1984	1983	1984
Manitowoc	590,315	532,220	50.8%	42.4%
Marinette	276,568.78	270,218	38.7%	36.7%
Marquette	57,766	105,228	31.1%	44.1%
Menominee	194,203	159,947	80.4%	80.1%
Milwaukee	19,891,028	21,758,576	50.1%	49.8%
Monroe	112,811	93,925	18.3%	14.2%
Oconto	128,384	152,660	48.5%	49.3%
Outagamie	804,315	1,206,716	45.1%	52.6%
Ozaukee	506,092.34	370,605	49.5%	41.6%
Pepin	23,628	5,822	20.6%	9.3%
Pierce	86,735	68,507	27.9%	21.7%
Portage	300,937	426,453	29.8%	37.5%
Racine	1,810,987.93	2,043,861	57.4%	51.5%
Rock	1,195,542	1,464,179	66.1%	57.1%
St. Croix	174,773	158,522	24.5%	23.4%
Sawyer	174,118	115,824	50.0%	33.8%
Shawano/Waupaca	561,203	404,137	40.8%	31.6%
Sheboygan	729,232	745,382	37.2%	41.0%
Taylor	111,514.42	156,849	41.4%	52.4%
Vernon	153,806	95,697	38.8%	23.9%
Walworth	652,094	622,315	35.3%	34.2%
Washington	635,543	720,704	42.0%	43.1%
Waukesha	1,909,632	1,926,140	47.8%	45.9%
Waushara	27,986	60,222	7.7%	13.6%
Winnebago	1,120,408	1,789,726	41.7%	51.3%
Wood	795,789	661,713	48.8%	40.9%

SOURCE: Wisconsin DHSS, Office of Mental Health.

APPENDIX C

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1983

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1983

COUNTY	OUTPATIENT EXPENDITURES	OUTPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	RESIDENTIAL EXPENDITURES	RESIDENTIAL EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES
Adams	$103,255	42.7%	$9,069	3.8%	$10,385	4.3%
Ashland/Iron Price	$181,926	31.1%	$27,424	4.7%	$23,910	4.1%
Barron/Burnett Polk/Rusk/ Washburn	$592,993	37.4%	$1,022	0.06%	$128,410	8.1%
Bayfield	$17,841	13.3%	$1,149	0.9%	$29,829	22.2%
Brown	$996,126	19.7%	$175,432	3.5%	$35,575	0.7%
Buffalo/ Jackson/ Trempealeau	$208,800	22.2%	$43,635	4.7%	$60,904	6.5%
Calumet	$97,029	24.5%	$64,343	16.2%	$20,048	5.05%
Chippewa	$224,671	36.4%	$17,907	2.9%	$50,815	8.2%
Clark	$77,083	19.4%	$71,532	18.04%	$12,442	3.1%
Columbia	$225,220	37.6%	$3,414	0.6%	$1,982	0.3%
Crawford	$122,083	33.8%	$15,489	4.3%	$30,024	8.3%
Dane	$2,144,121	39.1%	$450,202	8.2%	$875,280	15.9%
Dodge	$397,694	40.5%	$50,358	5.1%	$99,360	10.1%
Door	$69,984	17.3%	0	0	0	0
Douglas	$206,334	17.8%	$6,974	0.6%	$106,055	9.05%
Dunn	$355,075	51.08%	$13,579	1.9%	$44,430	6.4%
Eau Claire	$429,648	29.3%	$111,000	7.6%	$204,054	13.9%
Florence	$32,447	54.6%	$3,405	5.7%	$911	1.5%
Fond Du Lac	$646,125	41.3%	$141,942	9.07%	$37,850	2.4%
Forest/Oneida Vilas	$299,750	31.4%	$9,352	1.0%	$19,957	2.1%
Grant/Iowa	$474,020	45.0%	$3,346	0.3%	$7,078	0.7%
Green	$129,120	26.7%	$26,492	5.5%	$66,501	13.8%
Green Lake	$97,726	55.4%	$4,312	2.4%	$4,136	2.3%
Jefferson	$270,411	27.1%	$40,165	4.0%	$16,763	1.6%
Juneau/ Richland/Sauk	$740,954	34.7%	$62,190	2.9%	$143,719	6.7%
Kenosha	$512,405	19.7%	$59,268	2.3%	$258,804	9.9%
Kewaunee	$111,420	65.0%	$3,779	2.2%	$0	0.0%
LaCrosse	$538,338	44.1%	$123,954	10.1%	$117,985	9.7%
Lafayette	$84,796	43.6%	$52,728	27.1%	$16,280	8.4%
Langlade/ Lincoln/ Marathon	$1,840,251	38.6%	$146,672	3.1%	$288,285	6.1%

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APPENDIX C TABLE (CONTINUED)

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1983

COUNTY	OUTPATIENT EXPENDITURES	OUTPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	RESIDENTIAL EXPENDITURES	RESIDENTIAL EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES
Manitowoc	$410,562	35.3%	$54,772	4.7%	$6,064	0.5%
Marinette	$289,318	40.5%	$450	0.1%	$28,679	4.0%
Marquette	$105,071	56.5%	$3,869	2.1%	$582	0.3%
Menominee	$22,865	9.5%	$0	0.0%	$0	0.0%
Milwaukee	$14,262,282	36.0%	$1,110,373	2.8%	$2,303,278	5.8%
Monroe	$226,836	36.9%	$115,660	18.8%	$64,400	10.5%
Oconto	$130,419	49.3%	$0	0.0%	$1,400	0.5%
Outagamie	$453,968	25.4%	$103,302	5.8%	$35,748	2.0%
Ozaukee	$189,652	18.6%	$55,005	5.4%	$172,308	16.9%
Pepin	$15,887	13.8%	$4,745	4.1%	$8,355	7.3%
Pierce	$165,065	53.1%	$411	0.1%	$17,425	5.6%
Portage	$527,018	52.1%	$56,002	5.5%	$98,550	9.7%
Racine	$125,423	4.0%	$0	0.0%	$807,887	25.6%
Rock	$453,405	25.1%	$36,130	2.0%	$1,300	0.1%
St. Croix	$340,232	47.8%	$36,075	5.1%	$56,703	8.0%
Sawyer	$152,249	43.7%	$4,615	1.3%	$5,313	1.5%
Shawano/ Waupaca	$473,065	34.4%	$143,424	10.4%	$33,433	2.4%
Sheboygan	$681,941	34.8%	$133,140	6.8%	$304,341	15.5%
Taylor	$82,967	30.8%	$5,161	2.0%	$21,125	7.8%
Vernon	$159,687	40.3%	$33,642	8.5%	$17,864	4.5%
Walworth	$422,250	22.9%	$48,859	2.6%	$281,977	15.3%
Washington	$591,366	39.1%	$135,218	8.9%	$98,824	6.5%
Waukesha	$257,450	6.4%	$150,855	3.8%	$378,227	9.5%
Waushara	$244,215	67.0%	$74,041	20.3%	$10,282	2.8%
Winnebago	$952,003	35.4%	$201,241	7.5%	$148,097	5.5%
Wood	$607,109	37.2%	$53,355	3.3%	$80,894	5.0%

NOTE: Percentages do not equal 100% because expenditures for all mental health services are not included in the Table.

SOURCE: Wisconsin DHSS, Office of Mental Health.

APPENDIX D

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1984

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1984

COUNTY	OUTPATIENT EXPENDITURES	OUTPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	RESIDENTIAL EXPENDITURES	RESIDENTIAL EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES
Adams	$145,273	28.0%	$9,082	3.9%	$11,071	4.7%
Ashland/Iron						
Price	$169,808	27.3%	$29,211	4.7%	$40,734	6.5%
Barron/Burnett						
Polk/Rusk/						
Washburn	$559,471	31.9%	$2,271	0.1%	$210,831	12.0%
Bayfield	$60,848	45.1%	$0	0.0%	$18,071	13.4%
Brown	$1,143,029	21.3%	$207,512	3.9%	$50,379	0.9%
Buffalo/						
Jackson/						
Trempealeau	$161,600	15.7%	$36,720	3.6%	$135,736	13.2%
Calumet	$149,543	33.2%	$61,587	13.7%	$34,622	7.7%
Chippewa	$224,595	46.4%	$15,419	3.2%	$44,539	9.2%
Clark	$178,000	28.3%	$110,664	17.6%	$8,660	1.4%
Columbia	$267,973	48.6%	$154	0.03%	$10,309	1.9%
Crawford	$124,586	36.4%	$14,237	4.20%	$15,832	4.6%
Dane	$2,314,817	37.1%	$481,221	7.7%	$932,784	15.0%
Dodge	$462,580	33.9%	$49,051	3.6%	$149,130	10.9%
Door	$103,557	22.4%	$1,657	0.40%	$0	0.0%
Douglas	$243,116	23.3%	$3,000	0.3%	$109,363	10.5%
Dunn	$294,332	36.8%	$26,286	3.3%	$26,692	3.3%
Eau Claire	$365,111	26.2%	$115,586	8.3%	$262,156	18.8%
Florence	$20,437	45.3%	$0	0.0%	$0	0.0%
Fond Du Lac	$652,836	41.8%	$138,309	8.9%	$45,359	2.9%
Forest/Oneida						
Vilas	$324,917	31.5%	$9,142	0.9%	$42,149	4.1%
Grant/Iowa	-----	-----	-----	-----	-----	-----
Green	$128,603	23.6%	$27,448	5.0%	$41,851	7.7%
Green Lake	$97,153	53.0%	$3,829	2.1%	$2,350	1.3%
Jefferson	$294,964	35.7%	$57,724	7.0%	$19,674	2.4%
Juneau/						
Richland/Sauk	$864,301	34.9%	$124,239	5.0%	$142,645	5.8%
Kenosha	$486,776	17.4%	$53,087	1.9%	$238,649	8.5%
Kewaunee	$124,821	46.7%	$20,251	7.6%	$1,794	0.7%
LaCrosse	$596,006	41.5%	$108,789	7.6%	$141,032	9.9%
Lafayette	$74,118	42.6%	$55,079	31.7%	$11,661	6.7%
Langlade/						
Lincoln/						
Marathon	$1,617,270	42.8%	$31,115	0.8%	$243,070	6.4%

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APPENDIX D TABLE (CONTINUED)

EXPENDITURES FOR OUTPATIENT, SHELTERED EMPLOYMENT, AND RESIDENTIAL PROGRAMS, BY COUNTY MENTAL HEALTH BOARDS, 1984

COUNTY	OUTPATIENT EXPENDITURES	OUTPATIENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES	SHELTERED EMPLOYMENT EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES	RESIDENTIAL EXPENDITURES	RESIDENTIAL EXPENDITURES AS PERCENTAGE OF TOTAL EXPENDITURES
Manitowoc	$548,990	43.8%	$55,855	4.4%	$17,257	1.4%
Marinette	$294,090	40.0%	$5,297	0.7%	$1,084	0.1%
Marquette	$122,967	51.5%	$522	0.2%	$2,770	1.2%
Menomfee	$30,067	12.4%	$0	0.0%	$0	0.0%
Milwaukee	$8,246,220	37.7%	$695,440	1.6%	$2,760,547	6.3%
Monroe	$351,212	53.0%	$102,603	15.5%	$64,927	9.8%
Oconto	$153,221	49.5%	$0	0.0%	$166	0.1%
Outagamie	$488,853	21.3%	$126,340	5.5%	$40,136	1.8%
Ozaukee	$205,932	23.1%	$53,929	6.05%	$187,471	21.0%
Pepin	$31,853	51.0%	$9,500	15.2%	$7,470	11.9%
Pierce	$213,262	67.6%	$4,817	1.5%	$5,075	1.6%
Portage	$519,949	45.7%	$38,044	3.3%	$110,546	9.7%
Racine	$715,982	18.0%	$2,366	0.6%	$855,154	21.5%
Rock	$644,601	25.1%	$30,000	1.2%	$38,802	1.5%
St. Croix	$395,303	58.4%	$0	0.0%	$61,158	9.0%
Sawyer	$162,461	47.4%	$6,068	1.8%	$9,105	2.7%
Shawano/ Waupaca	$463,335	36.3%	$174,336	13.6%	$26,863	2.1%
Sheboygan	$488,548	26.9%	$151,208	8.3%	$326,537	18.0%
Taylor	$84,169	28.1%	$6,897	2.3%	$27,091	9.1%
Vernon	$197,066	49.1%	$34,207	8.5%	$32,924	8.2%
Walworth	$585,213	32.1%	$94,053	5.2%	$373,129	20.5%
Washington	$638,130	38.2%	$153,046	9.2%	$104,766	6.3%
Waukesha	$1,178,934	28.1%	$193,115	3.4%	$633,941	15.1%
Waushara	$261,879	59.2%	$71,806	16.2%	$22,337	5.1%
Winnebago	$983,518	28.2%	$231,716	6.6%	$161,974	4.6%
Wood	$692,613	42.8%	$62,952	3.9%	$86,954	5.4%

NOTE: Percentages do not equal 100% because expenditures for all mental health services are not included in the Table.

SOURCE: Wisconsin DHSS, Office of Mental Health.

APPENDIX E

SOCIAL AND MENTAL HEALTH SERVICES FUNDED BY COMMUNITY AIDS FOR WHICH FEES ARE EXEMPT, OPTIONAL AND MANDATORY

SOCIAL AND MENTAL HEALTH SERVICES FUNDED BY COMMUNITY AIDS FOR WHICH FEES ARE EXEMPT, OPTIONAL AND MANDATORY

Services Which are Exempt from Fees

Adoption services
Services provided to the courts
Sheltered employment, work activity and adult nonmedical day services
Programs for the handicapped, except transportation related to these services
Nonmedical initial diagnosis and evaluation services
Family planning services
Advocacy
Child support and paternity establishment services for recipients of aid to families with dependent children
Outreach, information and referral services
Some residential treatment services provided to children for alcohol and drug abuse
Other services, if H&SS determines a fee to be administratively unfeasible

Services for Which Counties May Charge a Fee*

Adult day care
Supportive home care
Housing//energy assistance
Transportation services
Work-related services
Daily living skills training
Adoption investigations and services ordered under 48.837 (Milwaukee County only)
Shelter care (other than that provided under Chapter 48)
Child custody studies under a petition to the court
Congregate and home delivered meals
Recreation activities
Protective payment
Crisis intervention
Counselling
Community support
Case management

*Only to persons with incomes at or above 70% of the state median.

Services for Which Counties Must Charge a Fee

Child day care (if income is at or above 50% of the state median)
Foster and group home care
Shelter care under Chapter 48
Child caring institutional care
Community-based treatment facilities care
Medical day services

SOURCE: Community Aids: Financial Assistance to Counties for Human Services; State of Wisconsin Legislative Fiscal Bureau, January 1985.